



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

GABRIEL JASSO, PsyD

Respondent Name

MARKEL INSURANCE CO

MFDR Tracking Number

M4-17-0678-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

NOVEMBER 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR REFERRED TESTING."

Amount in Dispute: \$400.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "no additional reimbursement should be awarded to Requestor as they improperly billed the number of units of each examination/testing performed and did not comply with the CPT code descriptions in billing or in documenting their report. Respondent made a good faith effort to reimburse Requestor despite their failure to bill and document correctly."

Response Submitted By: Downs & Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2016	CPT Code 96116 (4 Units)	\$568.00	\$0.00
	CPT Code 96118 (20 Units)	\$2,960.00	\$0.00
TOTAL		\$3,528.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 663-Reimbursement has been calculated according to the state fee schedule guidelines.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - B52-Additional information is needed to review this code.
 - B12-Services not documented in patients' medical records.
 - Per review by coding specialist, without time units documented in the medical records units have been combined to allow charges at per hour based on description of codes billed. If you disagree with the number of hours billed please resubmit with documentation showing the length of time testing took.
 - 18-Exact duplicate claim/service.

Issues

Does the documentation support billing CPT code 96614 (X4) and 96118 (X20)? Is the requestor entitled to additional reimbursement?

Findings

28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203 (b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

On the disputed date of service, the requestor billed CPT codes 96116 and 96118.

CPT code 96116 is defined as "Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report."

CPT code 96118 is defined as "Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report."

The code descriptor for both codes indicate that they are billed and reported per hour. The requestor billed four (4) hours of code 96116 and twenty (20) hours of code 96118 for a total of twenty-four (24) hours.

According to the explanation of benefits, the respondent paid \$941.01 based upon "Per review by coding specialist, without time units documented in the medical records units have been combined to allow charges at per hour based on description of codes billed. If you disagree with the number of hours billed please resubmit with documentation showing the length of time testing took."

A review of the submitted medical records do not support a start and end time for the exam and testing, interpreting test results and preparing report support the twenty-four hours billed. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	12/14/2016 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.